

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

The Lancaster County Community Mental Health Center/Crisis Center is required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. §1320d *et seq.*, 45 C.F.R. Parts 160 and 164, and the Confidentiality Law, 42 U.S.C. §290dd-2, 42 C.F.R. Part 2. Under these laws, the Community Mental Health Center/Crisis Center may not say to a person outside the Community Mental Health Center/Crisis Center that you attend a program, nor may we disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law. We must follow the privacy practices contained in this notice. However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. A current notice will be available and posted at all times at the Community Mental Health Center/Crisis Center.

## **USE AND DISCLOSURE OF YOUR HEALTH INFORMATION ONLY WITH YOUR AUTHORIZATION:**

Uses and disclosures of your health information will be made only with your written authorization. We must obtain your written authorization before we can disclose information about you for payment purposes. For example, we must obtain your written authorization before we can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written authorization before we can share information for treatment purposes or for health care operations.

## **USE AND DISCLOSURE OF YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION:**

Federal law permits us to use and disclose information about you without your written permission in the following instances:

1. To persons or organizations known as business associates, who provide services for us under contract. We require our business associates to protect the medical information we provide to them.
2. To qualified personnel for research.
3. To qualified personnel for audit or program evaluations.
4. To report a crime committed by you on the Community Mental Health Center/Crisis Center premises or against Community Mental Health Center/Crisis Center personnel.
5. To medical personnel in a medical emergency situation.
6. To appropriate authorities to report suspected child abuse or neglect.
7. As allowed by a court order.

## **YOU HAVE SEVERAL RIGHTS WITH REGARD TO YOUR HEALTH INFORMATION:**

**Right To Inspect And Copy.** You have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes; information gathered in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. You may be charged a reasonable fee for a copy of your records.

**Right to Request To Correct Or Amend.** If you believe your health information is incorrect, you may ask us to correct or amend the information. Your request must be made in writing and must include a reason for the correction or change. If we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

**Right To Request Restrictions.** You have the right to ask for restrictions on how your health information is used or disclosed for treatment, payment and health care operations. Your request must be in writing and must include what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply. We are not legally required to agree with your requested restriction(s).

**Right To Request Confidential Communications.** You have the right to ask that we communicate your health information to you using alternative means or an alternative location. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We will accommodate reasonable requests.

**Right to An Accounting Of Disclosures.** You have the right to ask that we provide you with a list of the disclosures we have made of your health information after April 14, 2003. This list will not include disclosures made for treatment, payment or health care operations. This list will not include disclosures made to you or your legal representative, law enforcement/corrections regarding inmates, certain health oversight activities, our directory, national security or pursuant to your authorization.

**Right To Revoke Your Authorization.** If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing.

**Right To A Paper Copy Of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. We will not retaliate against you for filing such a complaint. In addition, violation of 42 C.F.R. Part 2 is a reportable crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurred.

**If you have any questions or concerns regarding your privacy rights, the information in this notice, or if you wish to file a complaint, please contact the following individual for information:**

Lancaster County Community Mental Health Center/Crisis Center  
ATTN: Privacy Officer  
2200 St. Mary's Avenue  
Lincoln, NE 68502  
(402) 441-7940

**This Notice of Privacy Practices is effective April 14, 2003.**

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of the Notice of Privacy Practices of the Lancaster County Community Mental Health Center/Crisis Center.

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Patient's/Personal Representative's Signature

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Date

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Community Mental Health Center/Crisis Center's staff should complete if Acknowledgment is not signed:

1. Does the patient have a copy of the Notice form?

☐ YES ☐ NO

2. Please explain why the patient was unable to sign an acknowledgment for and CMHC's efforts in trying to obtain the patient's signature:

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